FOR ADMINISTRATIVE USE

CDC INFLUENZA SURVEILLANCE REPORT

NO. 20 OCTOBER 8, 1957

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SPECIAL NOTE

Information contained in this report is a summary of data reported to CDC by State Health Departments, Epidemic Intelligence Service Officers, collaborating influenza diagnostic laboratories, and other pertinent sources. Much of it is preliminary in nature and is intended for those involved in influenza control activities. Anyone desiring to quote this information is urged to contact the person or persons primarily responsible for the items reported in order that the exact interpretation of the report and the current status of the investigation be obtained. State Health Officers, of course, will judge the advisability of releasing any information from their own states.

Table of Contents

I. Summary of Information

There has been a sharp increase in the number of counties reporting influenza outbreaks. Eighty-eight new counties have noted the occurrence of influenza during the past week, as compared with a total of 197 for the preceeding 18 weeks. Certain states in the Southwest, Northeast, and on the Pacific Coast appear to be most heavily involved at present. The Louisiana epidemic appears to be subsiding. Northern New England, the Northern Rocky Mountain area, and the South Atlantic States are least involved. Some of the larger cities of the Midwest -- notably Milwaukee, Grand Rapids, Kansas City -- have experienced epidemic influenza during the past week.

In the Northeast, New York City, and five counties in adjacent New Jersey developed epidemic situations virtually simultaneously. Epidemic influenza continues to sweep through Western New York State.

Although details of three more influenza-associated deaths have been reported, there is no evidence of significant increase in pneumonia and influenza mortality as reported in 108 cities. A total of 21 influenza-associated deaths have been reported to CDC.

Thirteen million five hundred four thousand nine hundred forty-seven ml of influenza vaccine have been released through October 1. This includes 2,833,856 ml released since September 25.

It is suggested that laboratories now report routine influenza findings only once monthly, but continue to give notice of unusual or important results, which may be of interest to the entire country.

Excessive use of antibiotics may cause development of resistant strains of bacteria, but Dr. Gail Dack, of the University of Chicago, mentions another possible result of antibiotic therapy. This is pseudomembranous enterocolitis which may result when intestinal flora are disturbed and enterotoxim producing staphylococci are able to thrive.

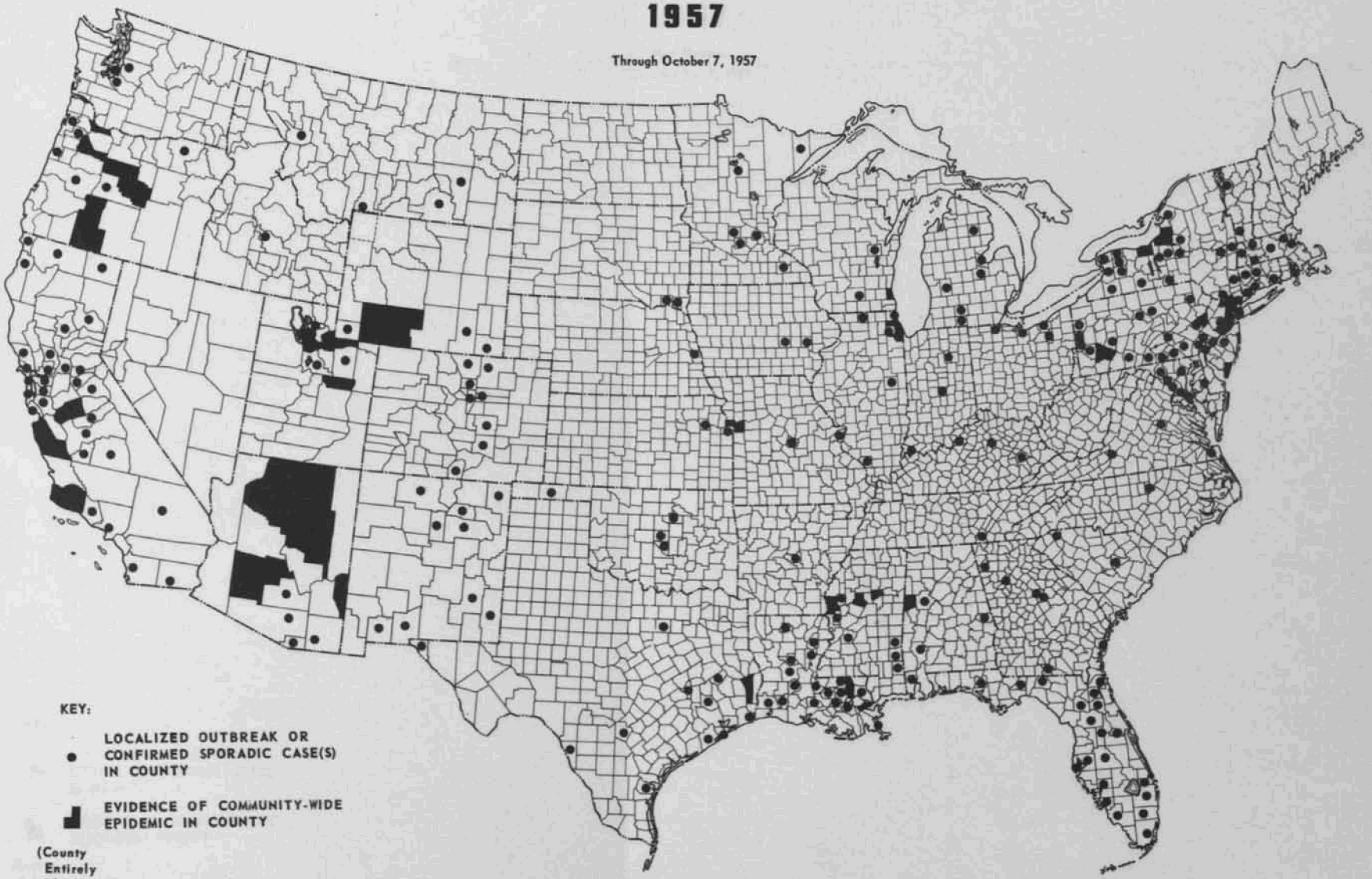
Myeloradiculitis is reported in a 26 year old physician following influenza vaccination. There was no past history of neuropathy.

Investigators who are conducting vaccine studies are requested to read Appendix A carefully, and to send a brief description of their study to the address listed.

A vaccine reaction study involving more than 2000 persons in most age groups in Montgomery County, Maryland which showed few significant reactions to vaccination is described in Appendix B.

ASIAN STRAIN INFLUENZA
1957

Through October 7, 1957



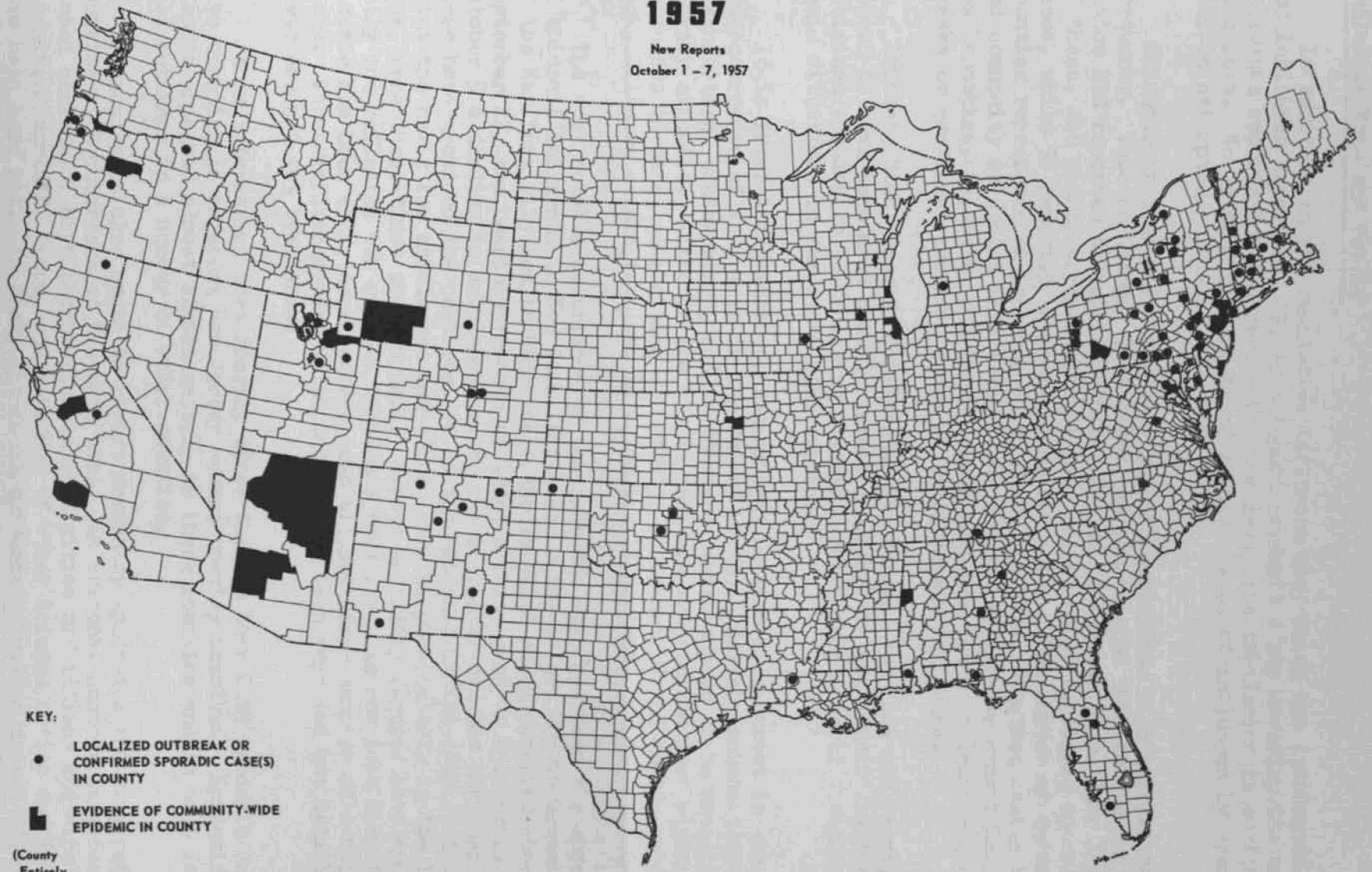
DHEW PHS-CDC

ATLANTA, GA. - APRIL, 1955

ASIAN STRAIN INFLUENZA

1957

New Reports
October 1 – 7, 1957



KEY:

- LOCALIZED OUTBREAK OR CONFIRMED SPORADIC CASE(S) IN COUNTY
- EVIDENCE OF COMMUNITY-WIDE EPIDEMIC IN COUNTY

(County Entirely Black)

DHEW-PHS-CDC

ATLANTA, GA. - APRIL, 1955

II. Influenza Maps and Tables

In addition to the cumulative influenza map, which was introduced in CDC Influenza Report No. 19, this Report presents a map covering the new influenza reports for the period October 1-7. The tabulation is continued as before. No listing of numbers of suspect cases of influenza by area will be attempted.

Epidemic influenza is appearing in new communities with increasing frequency. Through October 7 at least 285 counties of 3068 in the United States had reported outbreaks or epidemics of influenza (since June 1957). Of these, 246 counties reported localized outbreaks or confirmed sporadic cases, while 39 reported community-wide epidemics. The number of epidemic counties represents an increase of 23 over last week. Sixteen states have had community epidemics within their borders and all states except Maine, New Hampshire, Delaware, and North Dakota have now noted at least a few outbreaks or confirmed sporadic cases of Asian strain influenza.

Arizona, Utah, Oregon, California, New Jersey, New York and Pennsylvania appear to have been most heavily involved during the past week. Influenza in Louisiana appears to be declining somewhat. Certainly several sizeable epidemic situations in the state have subsided.

It is interesting that no geographical pattern is apparent in the present occurrence of influenza in the United States. Certain southeastern, northeastern, southwestern, and far-western states appear to be equally heavily affected. Although the Middle West has experienced less widespread influenza to date, some cities -- notably, Milwaukee, Grand Rapids, and Oak Park, Illinois -- are involved in epidemics at present.

The most notable occurrence of the past ten days has been the appearance of epidemic influenza in New York City. According to Dr. Morris Greenberg; of the New York City Health Department, the epidemic onset occurred about September 27, and possibly reached at least a first peak on October 2. By October 5 a decline in ambulance calls, clinic visits and the like was noted. These have provided the best measure of the epidemic in the city. At one point the calls for ambulances and clinic visits, particularly in the Harlem area, were three times above normal. Excess mortality figures have apparently not reflected the rise in incidence thus far. In New York City the disease has been mild, as elsewhere, and without large numbers of complications. Three influenza-associated deaths have been reported but details on these are not yet available.

It is interesting that shortly after the New York City epidemic onset, five counties in adjacent New Jersey became heavily involved. Epidemic influenza appeared almost simultaneously in these counties and in more localized settings in a number of other counties.

Pennsylvania also began to report community epidemics and many new counties with outbreaks at the same time. In Arizona, schools have been closed because of high absenteeism in such cities as Williams and Winslow. Phoenix, Flagstaff, Tempe, and a number of other Arizona cities and towns have been hard hit. In Utah, the focal epidemic situation around Salt Lake City has resulted in what appears to be concentric spread in Utah and into Wyoming. The widespread epidemic situation in western Oregon continues, and several counties in Central California have reported epidemics involving the general population.

Tabulation of Influenza Outbreaks, Confirmed Sporadic Cases, and Epidemics in the Continental United States June through October 7, 1957

State	No. counties in state	No counties reporting	
		Localized outbreaks or confirmed sporadic cases	Community-wide epidemics
Alabama	67	4	1
Arizona	14	4	4
Arkansas	75	1	0
California	58	29	3
Colorado	63	8	0
Connecticut	8	5	0
Delaware	3	—	
D. C.	—	1	0
Florida	67	20	0
Georgia	159	6	0
Idaho	44	1	0
Illinois	102	5	1
Indiana	92	3	0
Iowa	99	2	0
Kansas	105	2	1
Kentucky	120	3	0
Louisiana	64	17	2
Maine	16	—	
Maryland	23	6	0
Massachusetts	14	6	0
Michigan	83	6	0
Minnesota	87	6	0
Mississippi	82	6	3
Missouri	114	2	1
Montana	56	4	0
Nebraska	93	1	0
Nevada	17	Sporadic confirmed cases - counties not known	
New Hampshire	10	—	
New Jersey	21	3	6
New Mexico	32	9	0
New York	62	20	3
North Carolina	100	1	0
North Dakota	53	—	
Ohio	88	4	0
Oklahoma	77	4	0
Oregon	36	6	5
Pennsylvania	67	19	2
Rhode Island	5	1	0
South Carolina	46	2	0
South Dakota	68	2	0
Tennessee	95	1	0
Texas	254	10	1
Utah	29	3	4
Vermont	14	2	0
Virginia	98	3	0
Washington	39	3	0
West Virginia	55	Sporadic confirmed cases - counties not known	
Wisconsin	71	2	1
Wyoming	23	3	1
Totals:	3068	246	39

III. Epidemic and Case Reports

1. Louisiana

Review of influenza situation through September 30

(Reported by Dr. Ben Freedman, Louisiana Department of Health, through Dr. C. C. Dauer, National Office of Vital Statistics)

First reports of outbreaks in 20 parishes were received at various times during the period July 14-September 27. Outbreaks have been confirmed as due to Asian strain influenza in 12 of these 20 parishes. Available epidemiologic data has resulted in an estimate of over 300,000 cases of influenza for the state between July 14 and September 30. The epidemic has appeared to spread from the southeastern part of the state toward the north and west. The epidemiological survey in Tangipahoa parish showed that approximately 20,000 persons contracted influenza-like illness between mid-July and early September. The epidemic peak in New Orleans was reached about one month ago and since that time there has been a gradual decrease in the daily numbers of cases reported. Most of the outbreaks in Louisiana have been reported from schools, colleges, and industrial groups. However better methods of recording illness are available for these groups than for the general population at home. Twelve deaths have now been attributed to influenza or its complications, and 9 additional deaths may be added to this group after further investigation. Detailed reports have become available on only four of the Louisiana influenza deaths to date.

2. Louisiana

Report from Charity Hospital, New Orleans

(Data provided by Hospital Staff and Dr. Ben Freedman, La. Dept. of Health)

Patients seen in the Admitting Room and the number with influenza-like illness.

Week Ending	NEGRO Total Patients Seen	NEGRO Flu-like Illness	NEGRO % of Total	WHITE Total Patients Seen	WHITE Flu-like Illness	WHITE % of Total
Aug. 10	2724	206	7.5	882	19	2.1
Aug. 17	2850	391	13.6	850	38	4.5
Aug. 24	3330	918	27.4	967	130	13.5
Aug. 31	5641	1479	26.0	1489	206	13.7
Sept. 7	5033	1414	28.0	1385	207	14.9
Sept. 14	4427	1123	25.2	1480	154	10.4
Sept. 21	4738	968	20.4	1600	228	14.2
Sept. 28	4743	947	20.0	1640	302	18.4

IV. Current Analysis of Influenza and Pneumonia Mortality

Table I

Current Influenza and Pneumonia Deaths
in 108 United States Cities*

Division	Number of Cities In Study	Number of Cities Reporting this week	Deaths (including estimates**) during weeks ending Sept. 21 (108 cities)	Sept. 28 (106 cities)	Oct. 5 (103 cities)
All Divisions	108	103	305	261	312
New England	14	14	21	19	26
Mid. Atlantic	17	17	87	69	88
E. North Central	18	17	61	50	53
W. North Central	9	8	19	18	18
S. Atlantic	9	8	22	19	20
E. South Central	8	8	15	12	16
W. South Central	13	12	36	41	37
Mountain	8	8	9	9	18
Pacific	12	11	35	24	36

**The number of deaths given includes estimates for cities not reporting in a given week. The table is corrected for preceeding weeks as late figures are received. The chart will be corrected only for gross discrepancies.

Comment

The West South Central Division continued this week at a level somewhat above normal, and the Mountain Division showed an increase. Other Divisions remained near normal levels. In the West South Central and Mountain Divisions excess deaths were concentrated in New Orleans, Denver, and Salt Lake City as shown in the following table:

Week Ending October 5, 1957 in Comparison with 1956 and 1955

	1957	1956	1955
West South Central			
Texas (7 cities)	12	9	9
Oklahoma			
Oklahoma City	3	-	1
Tulsa	4	4	2
Arkansas (Little Rock)	4	1	3
Louisiana			
Baton Rouge	2	-	-
New Orleans	8	2	2
Shreveport	4	-	3
Division Total	37	16	20
Mountain			
Denver	7	3	3
Salt Lake City	6	2	-
Other (6 cities)	5	4	5
Division Total	18	9	8

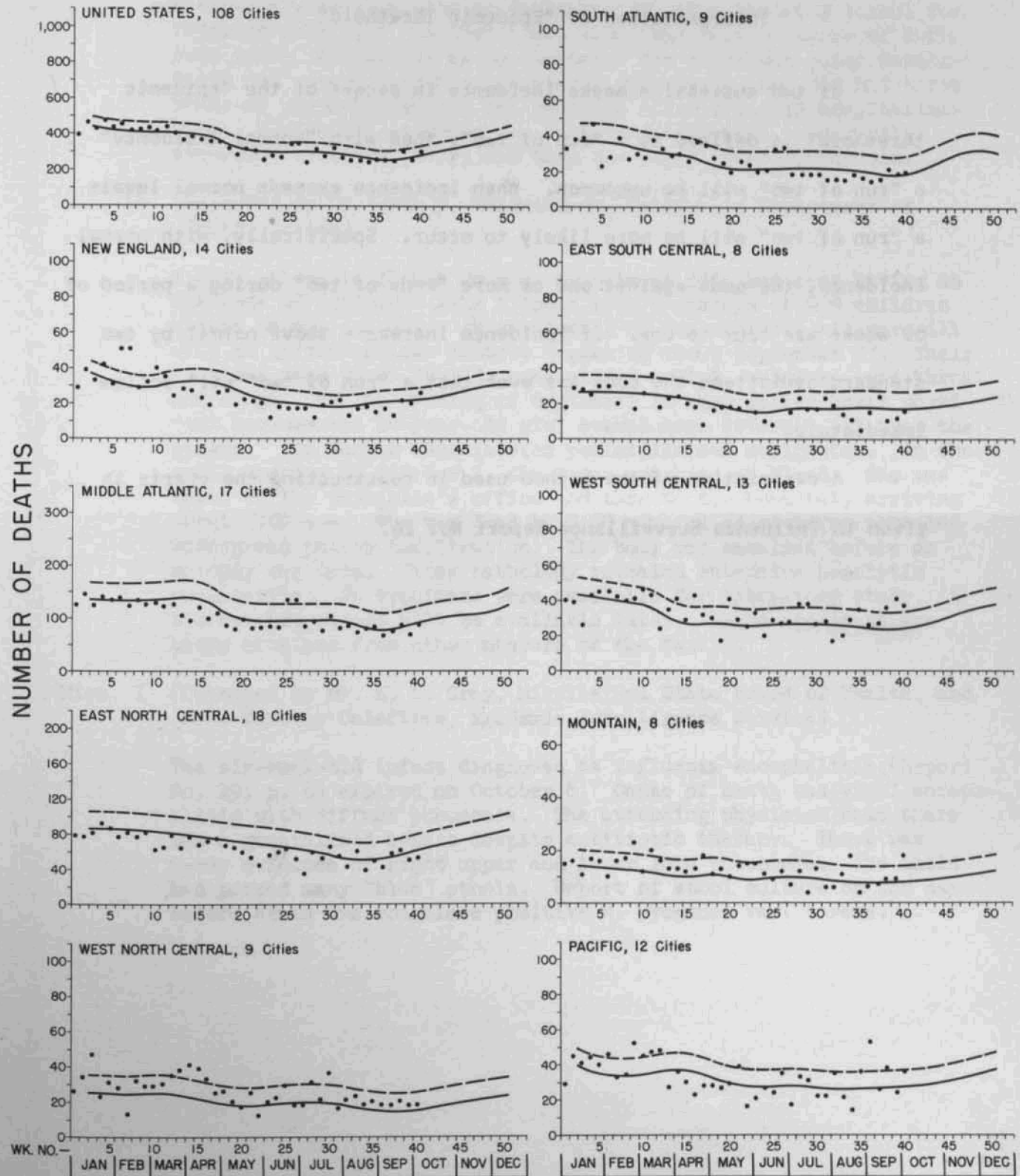
*Prepared by the Statistics Section, CDC

WEEKLY PNEUMONIA AND INFLUENZA DEATHS

"EPIDEMIC THRESHOLD"

"NORMAL INCIDENCE"

(SEE EXPLANATION ON BACK OF SHEET)



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ATLANTA, GA. 58-70 SEPTEMBER, 1957

Interpretation of "Epidemic Threshold"

If two successive weeks incidence in excess of the "epidemic threshold" is defined as a "run of two", then with "normal incidence" a "run of two" will be uncommon. When incidence exceeds normal levels a "run of two" will be more likely to occur. Specifically, with normal incidence, the odds against one or more "runs of two" during a period of 52 weeks are four to one. If incidence increases above normal by two standard deviations the odds are even that a "run of two" will follow immediately.

A description of the method used in constructing the charts is given in Influenza Surveillance Report No. 16.

V. Influenza-Associated Deaths

Md. 1 (Reported by Dr. Charlotte Silverman, Maryland Department of Health, and Dr. Wilfred Ehrmantraut, D. C. Children's Center)

A two-year-old girl died on September 30, at a training school for retarded children. At that time, there had been 88 cases of influenza among 750 persons at the school. The child was quite debilitated and retarded with osteogenesis imperfecta, and had had three bouts of pneumonia during the pastyear which required hospitalization. During the epidemic she developed influenza, apparently recovered 24 hours later, and then developed bronchopneumonia.

Cal. 14 (Reported by Dr. Ruth M. Moldenhauer, California Department of Public Health)

A high school in Madera County, enrollment 675, has been having an outbreak of influenza-like illness with a maximum of 200 children absent on any one day. In one family of six members, all were ill with an influenza-like illness beginning about September 27. Their symptoms were fever 99-103, generalized aching, malaise, sore throat and cough. On the evening of September 30 they called their physician because the 14-year-old girl seemed more severely ill than the others. The doctor administered penicillin and analgesics. In the early morning of October 1, she began coughing up blood. She was taken to the physician's office and then to the hospital, arriving about 7:00 a.m. She was dead by 9:00 a.m. A chest x-ray revealed widespread patchy infiltration. The body was embalmed before an autopsy was done. Gross pathology revealed extensive hemolytic pneumonitis. No specimens were available for laboratory study. A microscopic report will be available later. Blood specimens are being obtained from other members of the family.

Miss. 1 (Reported by Dr. A. L. Gray, Mississippi State Board of Health, and Mrs. Dorothy Calafiore, Epidemic Intelligence Service)

The six-week-old infant diagnosed as influenza encephalitis (Report No. 19, p. 6) expired on October 6. Cause of death was viral encephalitis with diffuse pneumonia. The attending physician said there was a generalized sepsis despite antibiotic therapy. There was x-ray evidence of right upper and lower lobe pneumonia. The child had passed many "blue" stools. Report of stool culture on the day before death was coagulase positive M. pyogenes var. aureus.

VI. Influenza Vaccine Production and Distribution

Influenza Vaccine Released
(Totals through October 1, 1957)

Pharmaceutical Concern	Monovalent Asian strain	Polyvalent with Asian strain
Lederle	3,196,920 ml	473,280 ml
Lilly	837,310	16,335
Merck, Sharpe & Dohme	2,587,620	
National Drug	2,922,535	2,054,435
Parke Davis	228,770	
Pitman Moore	1,187,742	

Total released to date: 13,504,947 ml
Amount released since September 25: 2,833,856 ml

Shipping Distribution:

Department of Defense	4,011,420 ml
Commercial channels	9,491,527 ml

VII. Miscellany

1. Reporting of Laboratory Results

In view of the present situation with influenza diagnoses being made in a large number of cases all over the United States, the need for rapid communication of each result is not as great as previously. Laboratory results could now be summarized at the end of a month, and this could be sent to the International Influenza Center. In this way, we will learn how many tests are being conducted on a nation-wide scale and how many positive results are obtained each month. A summary of this information would then be published in the CDC Influenza Surveillance Report. Individual laboratories would not be identified in this summary. We would be interested in the number of isolations attempted and the number of complement-fixation, hemagglutination-inhibition, or neutralization tests performed and, with this, the number of specimens which would yield influenza virus and the number of paired sera with which a diagnostic fourfold increase in antibody titer was demonstrated. Of course, laboratory workers are urged to report immediately those results which have unusual significance, such as isolations in fatal cases or isolation of different strains or types.

2. Distribution of the Influenza Report

The Influenza Report is now being distributed as listed below:

	Approx. No.
State and Territorial Health Officers	53
State and Territorial Epidemiologists	60
State and Territorial Laboratory Directors	53
Cooperating laboratories	25
Epidemic Intelligence Officers, PHS officials	180
Medical schools - researchers and teachers	60
Department of Defense	15
Special AMA committee	5
Hospitals and others	65
Total	516

A letter has been sent to the Chairmen of Departments of Pediatrics, Internal Medicine, and Preventive Medicine in the U. S. medical schools, offering to place their names on the distribution list if desired. This has been done as a result of numerous requests from the schools for copies.

3. Bacteriophage Typing and Enterotoxin Production of Strains of Staphylococci from Post Influenza Staphylococcal Pneumonia - Dr. G. M. Dack, The University of Chicago

Influenza virus invading the lung tissues provides conditions for the multiplication of secondary invading bacteria. Since the widespread use of broad spectrum antibiotics in the treatment of infectious diseases, it has been demonstrated, particularly in hospitals, that certain types of staphylococci become resistant to the antibiotics in use. These antibiotic resistant strains of staphylococci have been typed with bacteriophages and identified as belonging in general to Group III. In this group are many strains of staphylococci which produce potent enterotoxin. Where antibiotics have been given which destroy the normal gastro-intestinal flora these enterotoxin-producing staphylococci may multiply and produce their poisons in the bowel. Cases of pseudomembranous enterocolitis have followed this sequence and have also occurred where antibiotic resistant staphylococci have been found in pulmonary lesions and not in the bowel.

It is to be expected, therefore, that gastro-intestinal symptoms in staphylococcal pneumonias complicating influenza may follow the invasion of the lungs with enterotoxigenic staphylococci. Bacteriophage typing may prove a very useful epidemiological tool in studying strains of staphylococci from post influenza staphylococcal pneumonia as well as from nose and throat cultures from contacts of the patients. Antibiotic resistant staphylococci, which have heretofore been associated with infections in hospitals, may occur in the home in the wake of an influenza epidemic.

4. Myeloradiculitis Associated with Influenza Vaccine - Reported by Drs. A. J. Steigman and David Copeland, University of Louisville Pediatrics Department

P. L. - 26 year old single white female
Occupation: Resident Physician, Pediatrics

9-16-57 Received 0.5 cc monovalent Asian influenza vaccine in right thigh subcutaneously. Reaction: 4 to 5 cm area of induration with erythema, no constitutional symptoms. Local reaction appeared within 24 hours and lasted about two days.

9-23-57 Received 0.5 cc polyvalent influenza vaccine containing types A and B with Asian strain. Local reaction of 4 to 5 cm of induration and erythema began within 24 hours and lasted about three days. This injection was given subcutaneously also in the left thigh. This local reaction had associated inguinal adenopathy, mild, lasting 3 to 4 days. Objectively beginning around 12 hours following second injection, the first of three shaking chills associate with temperature elevation of

101° to 102° was experienced. 16 hours following the injection there was mild dyspnea with coarse breath sounds and wheezing on auscultation. About 18 hours past injection and associated with the pain described was muscle tightness in the erector spinae group and those about the thighs. There were no mental changes or other signs of encephalitis. White blood count at this time was 8,800 total with slight increase in polymorphonuclears. 24 hours past injection there was difficulty in gait with a tendency to shuffling. 48 hours past injection the following findings were observed:

1. Bilateral Babinski signs
2. Diminished vibratory sensation in lower extremities
3. Ramberg's sign
4. Hyperactive deep tendon reflexes in lower extremities
5. Mild symmetrical weakness in lower extremities

No sphincteric changes noted. Recovery has been progressive and apparently complete. No throat washings or bacterial cultures were taken. Lumbar puncture was not done.

Receives desensitization injections of the following antigens for hayfever; (1) mixed grasses, (2) house dust, (3) ragweed. Although the patient had a personal and family history of skin allergy, she had no history of neuropathy. About 100 other persons received the vaccine without serious reaction.

Appendix A: CDC Influenza Surveillance Report No. 20

SURVEY OF INFLUENZA VACCINE TESTS

The PHS Influenza Research Committee, at its meeting on September 27, 1957, expressed concern with the lack of coordination of effort of field studies with Asian influenza vaccine, and with the paucity of centralized and generally available information on the plans of such studies. The Committee believed that it would be most helpful to all if, for this anticipated epidemic year, each investigator could know the general plan of other studies and thus avoid excessive repetition. In order to compile and then circulate to you and others the aggregate information, the Committee must know as soon as possible the general plan of each study now in progress or proposed.

I shall greatly appreciate, therefore, your cooperation in supplying the requisite information for studies which you are conducting or which are being conducted under your guidance or jurisdiction. Requests such as this are being circulated by appropriate committee members to committee members of the Armed Forces Epidemiological Board and of several institutes of the National Institutes of Health, to laboratories collaborating with the influenza study program and to various branches of the Armed Forces and Public Health Service.

The information desired is concerned only with plan of study and not with results. The Committee would like to know:

1. Are you conducting or proposing a study of Asian influenza vaccine efficacy?

2. Is the study under way or proposed? If the latter, what is the anticipated starting date?

3. What doses, route, and frequency of vaccine administered are to be used?

4. What are the characteristics of the group to be studied--such as type (institutional, Armed Forces, general population, etc.), size, age group, geographical location, etc.?

5. What cca values of vaccine will be used?

6. How will the efficacy of vaccine be assessed?

    a. By antibody response? (What type of antibody--CF, HI, etc.?)

    b. By observation for clinical disease in the presence of a natural outbreak of Asian influenza?

    c. By protection against challenge with influenza virus?

7. Will reactions to the vaccines administered be available?

The information will be compiled and distributed for the Committee by its Executive Secretary. Accordingly, it will expedite matters greatly if you will send the information directly to:

Dr. Roger M. Cole, Executive Secretary
PHS Influenza Research Committee
Room 104 Building 7
National Institutes of Health
Bethesda 14, Maryland

In addition, please send a copy to:

Dr. Keith E. Jensen
Chief, Respiratory Disease Unit
Communicable Disease Center
P. O. Box 61
Montgomery 1, Alabama

Appendix B: CDC Influenza Surveillance Report No. 20

PRELIMINARY REPORT ON REACTIONS TO INFLUENZA VACCINE, MONTGOMERY COUNTY, MARYLAND

Drs. Philip E. Sartwell and Raymond Seltser,
Johns Hopkins School of Hygiene and Public Health

A controlled field study of an "Asian strain" influenza virus vaccine is in progress. The subjects are members of family groups living in a suburban community in Maryland, who volunteered to participate. Subjects were given either vaccine or a control inoculation in accordance with a random assignment plan, and neither the subjects nor those observing the reactions knew which material an individual received. The vaccine was an aqueous, monovalent preparation administered subcutaneously in a dosage of 250 CCA units for adults, children receiving smaller doses as indicated in Table I. Snesitivity to eggs and the existence of acute febrile illness were the only conditions which were considered contraindications to vaccination in this ambulatory group. The controls received an injection of saline solution containing formalin in the same concentration (0.3%) as in the vaccine.

Each family was contacted by telephone at least once within the first 72 hours after vaccination; the majority were contacted more than once during this period. In practically every instance where any significant reaction was reported the subject was visited by a physician. Many of the school-age children were also checked by a physician at their schools.

Table I summarizes the observations made on the first 2,127 persons inoculated. In the interpretation of this table it must be emphasized that all symptoms developing within 72 hours after inoculation, however mild or transient, and whether or not it appeared reasonable to attribute them to the inoculation, are included. The term "fever" includes a few instances in which the temperature was not actually taken. Most reactions were quite mild and of brief duration, usually less than 24 hours. There were none that could be considered serious.

There are clear indications that some of the illnesses were unrelated to vaccination and were infectious episodes involving both vaccinated and unvaccinated members of the families. This is supported by the fact that almost as many of the controls as of the vaccinated subjects (10.5% vs. 12.7%) had constitutional symptoms, not accompanied by any local manifestation, following the inoculation. Respiratory infectious were prevalent in the community at the time of the study, and psychologic factors probably also were involved. It is perhaps reasonable to deduct the reaction frequency among controls from that among vaccinees. A rough estimate of total systemic reactions attributable to the vaccine at all ages would then be of the order of 5%. It is evident that, had no controls been employed in the study, an exaggerated view of the frequency of reactions might have resulted.

Local manifestations consisting of slight erythema, edema, pain or soreness at the site of inoculation were noted in 21% of vaccinated subjects and 6% of controls. These were usually so inconsequential that they are not entitled to be considered as "reactions."

In summary, systemic reactions attributable to the vaccine were rather infrequent, and nearly always mild. No serious reactions have been encountered. Since children less than one year of age were not studied, these findings cannot be applied to infants. Nor is there any certainty that other batches of vaccine, even when administered in the same dosage in terms of CCA units, will produce the same responses.

Table I

Frequency of Constitutional Reactions in Vaccinated Group and Control Group, by Age

Age group	Dosage CCA units	No. of subjects both groups combined	Vaccinated group				Control group			
			Fever		Total systemic reactions		Fever		Total systemic reactions	
			No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
Under 6	50	279	17	12.4	31	22.6	8	5.6	24	16.9
6-11	125	676	33	9.2	51	14.2	7	2.2	32	10.1
12-19	250	251	9	6.7	17	12.7	2	1.7	11	9.4
20-39	250	550	9	3.6	53	21.0	6	2.0	38	12.8
40 & over	250	371	7	3.4	31	15.2	1	0.6	22	13.2
All ages		2127	75	6.9	183	16.9	24	2.3	127	12.2